MO Book 3

State Plan 4.17 Liens and Adjustments or Recoveries

ATTACHMENT 4.17-A –

1. The State uses the following process for determining that an institutionalized individual cannot reasonably be expected to be discharged from the medical institution and return home:

The department has determined after notice and opportunity for hearing (Notice of Intent to File Medicaid TEFRA Lien - see attached Exhibit 1) that there is no reasonable expectation that the person can be discharged from the facility within one-hundred twenty days and return home. This may be substantiated by one of the following evidences:

(A) Applicant/beneficiary has been in the institution for longer than one- hundred twenty days.

(B) A physician states in writing that the applicant/beneficiary cannot be expected to be discharged evidenced by one of the following forms:

1) Form DA-124B, Department of Social Services - Missouri Division of Aging - Initial Assessment - Medical Summary - Section H - Physicians Evaluation and Recommendation. (See attached Exhibit 2);

2) Form DA-124C, Department of Social Services - Division of Aging - Nursing Facility Pre-Admission Screening/Resident Review for Mental Illness/Mental Retardation or Related Condition - Section B - Exemption Categories. (See attached Exhibit 3)

(C) An RN Assessment Coordinator states in writing that the applicant/beneficiary cannot be expected to be discharged evidenced by the "Minimum Data Set (MDS) - Version 2.0 for Nursing Home Resident Assessment and Care Screening - Full Assessment Form - Section Q - Discharge Potential". (See attached Exhibit 4)

2. The following criteria are used for establishing that a permanently institutionalized individual's son or daughter provided care as specified under regulations at 42 CFR §433.36(f):

Submission by a son or daughter of an affidavit swearing to residing in the home for at least two years immediately before the date of the individual's admission to the institution, residing there on a continuous basis since that time, and providing care which permitted the individual to reside at home rather than in an institution. (See attached Exhibit 5)

3. The State defines the terms below as follows:

- estate

  Estate is defined under §472.010(11) - "Estate" means the real and personal property of the decedent or ward, as from time to time changed in form by sale, reinvestment or otherwise, and augmented by any accretions and additions thereto and substitutions therefor, and diminished by any decreases and distributions therefrom.

- individual's home

  The principal place of residence of the individual. For town or city property, lots on which there is no dwelling and which adjoin the residence are considered part of the home (regardless of the number of lots so long as they are in the same city block). For rural property, the acreage on which the home is located plus any adjoining acreage will be considered part of the home.

- equity interest in the home

  Co-ownership of the home which is not the result of a transfer of property for less than the fair market value within thirty-six months prior to institutionalization.

- residing in the home for at least one or two years on a continuous basis, and

  Defined as physically residing in the home for at least one or two years on a continuous basis, with the exception of convalescent stays of a duration less than ninety days for each occurrence.

- lawfully residing.

  Residing in the home with the permission of the owner or, if under guardianship, the owner's legal guardian.

4. The State defines undue hardship as follows:

Claims are barred by statute, §473.398, if determined that 1) the cost of collection will exceed the amount of the State's claim; or 2) the collection of the claim will adversely affect the need of the surviving spouse or dependents of the decedent to reasonable care and support from the estate.

5. The following standards and procedures are used by the State for waiving estate recoveries when recovery would cause an undue hardship, and when recovery is not cost-effective:

Missouri's Medicaid estate recovery program is authorized by State law in the probate code. The State must pursue its claims against Medicaid decedent estates following the processes established by statute. Claims are barred by statute, §473.398, if determined that 1) the cost of collection will exceed the amount of the State's claim; or 2) the collection of the claim will adversely affect the need of the surviving spouse or dependents of the decedent to reasonable care and support from the estate.

The estate's attorney or other interested parties may raise any disputes with the State's attorney over the State's claim filed in probate. If the dispute cannot be resolved, the probate judge will render a ruling in a scheduled probate hearing. At that time, the court can decide if the State's claim is barred by reason of hardship.

6. The State defines cost-effective as follows (include methodology/thresholds used to determine cost-effectiveness):

The State voluntarily defines cost-effectiveness as: The cost of the collection will exceed the amount of the claim. However, if a dispute exists, the estate's attorney or other interested parties may raise any disputes, including cost-effectiveness, with the State's attorney over the State's claim filed in probate. If the dispute cannot be resolved, the probate judge will render a ruling in a scheduled probate hearing.

7. The State uses the following collection procedures (include specific elements contained in the advance notice requirement, the method for applying for a waiver, hearing and appeals procedures, and time frames involved):

The estate's attorney or other interested parties may raise any disputes with the State's attorney over the State's claim filed in probate. If the dispute cannot be resolved, the probate judge will render a ruling in a scheduled probate hearing.

MISSOURI DEPARTMENT OF SOCIAL SERVICES
DIVISION OF MEDICAL SERVICES
NOTICE OF INTENT TO FILE MEDICAID TEFRA LIEN

RECIPIENT/REPRESENTATIVE'S NAME
RECIPIENT/REPRESENTATIVE'S ADDRESS
ADDRESS1
CITY STATE ZIP

RE: Recipient Name
DCN #

This is to notify you that based on approval of your application for medical assistance, your home and other real property(ies) are subject to a TEFRA lien. A TEFRA lien is a claim on the property of a person as security for payment of a just debt authorized by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA). The lien will be for the debt due the state for medical assistance paid or to be paid on your behalf.

A lien may be placed on a person's home and other real property when all of the following conditions are met:

- When the person lives or is going to live in a long term care facility.
- When the person owns a home or other real property.
- When there is no reasonable expectation that the person will be discharged from the long term care facility and resume living in the home within one-hundred twenty days of admission. You have the right to appeal the decision that you are not expected to return home within one-hundred twenty days of admission. The procedures for requesting a hearing are on the back of this letter.
- When the person does not have a spouse, child under twenty-one years of age, or child who is blind or permanently disabled living in the home.
- When the person does not have a brother or sister who has an equity interest in the property and who was residing in the home at least one year immediately before the date of the person's admission to a long term care facility.
- When the person does not have a son or daughter who has been residing in the home on a continuous basis for at least two years immediately before the date of admission, providing care which permitted the person to reside at home rather than in an institution.

If you do not meet all of these conditions, please contact the Division of Medical Services, TEFRA Lien Recoveries, P.O. Box 6500, Jefferson City, MO 65102-6500, (573) 751-2005.

A lien on property does not change the ownership of the property. It only represents a debt that must be satisfied whenever the property is sold, transferred, or leased. Missouri Medicaid does not require a medical assistance recipient to sell his/her home. The purpose of the TEFRA lien is to secure property so that medical costs can be recovered by the State when the property is sold, transferred, or leased.

The TEFRA lien will be released in the event the person is discharged from the long term care facility and resumes living in the home.

Please note that if the applicant/recipient objects to the placement of the TEFRA lien, the applicant/recipient may made ineligible for medical assistance.

RIGHT TO APPEAL

If you are dissatisfied with any action or failure to act with regard to your medical assistance, you have the right to appeal. Your rights and procedures for hearing are explained in the Missouri Division of Family Service's pamphlet "Important Information About Your Hearing Rights" (IM-4).

Before you request a hearing, request a conference with the Medicaid TEFRA Lien Recovery worker and his/her supervisor to discuss the proposed action. If you still disagree with the decision, request a hearing through your local DFS caseworker....

- The hearing is held locally either by speaker-telephone or in-person without cost to you and the setting is informal.
- You may represent yourself or have a friend or relative do so.
- You will not need a lawyer, but may have legal representation if you desire it. If you do not have an attorney or cannot afford one, and live in an area served by legal aid or legal services office, you may be eligible for these services.

FOLLOW THESE STEPS:

- **REQUEST A HEARING THROUGH YOUR LOCAL DFS CASEWORKER**
- **PREPARE FOR THE HEARING BY GATHERING INFORMATION ABOUT YOUR CASE**
- **ATTEND THE HEARING**

Detailed instructions and information can be found in Missouri Division of Family Service's pamphlet "Important Information About your Hearings Rights" (IM-4).

MS 96-11

EXHIBIT 2

To be completed by Attending Physician

Department of Social Services – MISSOURI DIVISION OF AGING

INITIAL ASSESSMENT—MEDICAL SUMMARY

DA-124 B (Rev. 4/84)

PATIENT'S NAME (LAST, FIRST, MIDDLE) _____ D. O. B. _____ CASE #: ALPHA / PAY CO. / DCN _____

MEDICAL INFORMATION — Date of last medical examination _____

27. Physical Information:
   1) Height _____
   2) Weight _____
   3) B/P _____
   4) Pulse _____

28. Medical Incidents: Dates / Types
   1 ☐ Recent CVA _____
   2 ☐ Recent Surgery _____ _____
   3 ☐ Recent Fracture _____ _____
   4 ☐ Other: _____ _____

29. Residual Effects: _____

30. Special Lab Tests:
   1) _____
   2) _____
   3) _____

31. Stability:
   1 ☐ Improving
   2 ☐ Stable
   3 ☐ Deteriorating
   4 ☐ Unstable

32. Prescription Drugs:
   1) _____ 5) _____
   2) _____ 6) _____
   3) _____ 7) _____
   4) _____ 8) _____

33. Medical Status – Current Diagnoses:
   1) _____
   2) _____
   3) _____
   Other: _____

34. Other Comments: _____

F. FUNCTIONAL LEVELS (Check only those which apply.)

35. Functional Impairment:

	Min	Mod	Max	
1	☐	☐	☐	Vision
2	☐	☐	☐	Hearing
3	☐	☐	☐	Speech
4	☐	☐	☐	Ambulation
5	☐	☐	☐	Manual Dexterity

36. Behavioral Information:

	Min	Mod	Max	
1	☐	☐	☐	Confused
2	☐	☐	☐	Withdrawn
3	☐	☐	☐	Hyperactive
4	☐	☐	☐	Wanders
5	☐	☐	☐	Suspicious
6	☐	☐	☐	Combative
7	☐	☐	☐	Supervised For Safety
8	☐	☐	☐	Causes Mgt. Problems
9	☐	☐	☐	Controlled with Medications(s)

37. Mental Status:

	Yes	No	
1	☐	☐	Lucid
2	☐	☐	Labile
3	☐	☐	Comatose
4	☐	☐	Semi-Comatose
5	☐	☐	Mentally Retarded

IQ _____ LEVEL OF FUNCTIONING _____

G. PATIENT CARE ASSESSMENT

38. Ordered Rehabilitative Services: (Enter frequency per week.)
   1 _____ Physical Therapy
   2 _____ Speech Therapy
   3 _____ Occupational Therapy
   4 _____ Other: _____

39. Specialized Nursing Procedures Required: (Check those which apply.)
   1 ☐ Bowel & Bladder
   2 ☐ Catherization Care
   3 ☐ Colostomy Care (Ileostomy Care)
   4 ☐ Decubitus Care
   5 ☐ Diabetic Urine Test
   6 ☐ Fracture Care
   7 ☐ Gastrostomy
   8 ☐ Inhalation Therapy
   9 ☐ Intake & Output
   10 ☐ I.V. Fluid
   11 ☐ Oral Suction
   12 ☐ Oxygen
   13 ☐ Prosthesis Care
   14 ☐ Restraints
   15 ☐ Special Skin Care
   16 ☐ Sterile Dressings
   17 ☐ Therapeutic Diets
   18 ☐ TPR/BP
   19 ☐ Tracheostomy Care
   20 ☐ Tube Feedings
   21 ☐ Other: _____

40. ASSESSED NEEDS: (Check only those which apply and give rationale for assessment)

	Min	Mod	Max	
1	☐	☐	☐	Mobility _____
2	☐	☐	☐	Dietary _____
3	☐	☐	☐	Restorative Services _____
4	☐	☐	☐	Monitoring _____
5	☐	☐	☐	Medication _____
6	☐	☐	☐	Behavior/Mental Cond. _____
7	☐	☐	☐	Treatments _____
8	☐	☐	☐	Personal Care _____
9	☐	☐	☐	Rehab. Services _____

41. DA State Office Use ONLY

H. PHYSICIAN'S EVALUATION AND RECOMMENDATION:

	Yes	No	
42.	☐	☐	Does medical regimen of patient need to be under the supervision of an MD/DO?
43.	☐	☐	Will a nursing facility be capable of providing the needed care?
44.	☐	☐	If placed in a nursing facility, would you have plans for evantual discharge?

45. What is this patient's prognosis?
   1 ☐ Improvement
   2 ☐ Stabilization
   3 ☐ Deterioration
   4 ☐ Instability

46. Current condition has existed since _____

47. Level of Care Determination — In my opinion this patient's medical condition and/or functioning capabilities qualify for the following level of care:
   1 ☐ Acute Care Hospital
   2 ☐ Skilled Nursing Facility
   3 ☐ Intermediate Care Facility
   4 ☐ Intermediate Care Facility – Mentally Retarded
   5 ☐ Mental Hospital
   6 ☐ Residential Care Facility
   7 ☐ Adult Boarding Facility

48. Alternative Determination — Although this patient's condition qualifies for care in at least an intermediate care facility, in my opinion, institutionalization may be avoided at this time by the provision of the following services within the patient's home.
   1 ☐ Home-Health
   2 ☐ Personal Care
   3 ☐ Homemaker/Chore
   4 ☐ Day Care/Treatment
   5 ☐ Adult Family Care
   6 ☐ Respite
   7 ☐ Other: _____

ATTENDING PHYSICIAN'S SIGNATURE _____ ADDRESS _____

DATE _____ TELEPHONE _____ CITY _____ COUNTY _____

REFERRAL DISTRIBUTION:
WHITE ORIGINAL, CANARY and PINK COPY — DFS Co. Office
GOLDENROD COPY — Facility or Physician

DFS DISTRIBUTION:
WHITE ORIGINAL and CANARY COPY — DA Central Office
PINK COPY — DFS Co. Office File

DA DISTRIBUTION:
WHITE ORIGINAL — DA Central Office
CANARY COPY — DFS Co. Office

State Plan TN# 96-11 Effective Date April 1, 1996 EXHIBIT 3

Supersedes TN# NA Approval Date AUG 1 1996 Page 1

STATE OF MISSOURI
DEPARTMENT OF SOCIAL SERVICES - DIVISION OF AGING

NURSING FACILITY PRE-ADMISSION SCREENING/RESIDENT REVIEW FOR MENTAL ILLNESS/MENTAL RETARDATION OR RELATED CONDITION

USE — COMPLETION OF THIS FORM IS MANDATORY FOR ALL PERSONS RESIDING IN OR APPLYING TO RESIDE IN MEDICAID CERTIFIED
F. ..ITIES AFTER 1/1/89 TO DETERMINE APPROPRIATENESS OF THE NURSING FACILITY PLACEMENT.

A. IDENTIFYING INFORMATION

1 PERSON'S NAME (LAST, FIRST, MIDDLE)		FOR STATE OFFICE USE ONLY: DCN CASE NUMBER	DMH NUMBER
2 SOCIAL SECURITY NUMBER	3 SEX ☐ MALE ☐ FEMALE / RACE	4 DATE OF BIRTH	5 NAME OF NURSING FACILITY (IF KNOWN)
6 CURRENT STREET ADDRESS			PERSON'S PHONE NUMBER
7 CITY	8 STATE / 9 ZIP	10 COUNTY	11 DAYTIME PHONE NUMBER FOR KEY INFORMANT

12. CHECK THE APPROPRIATE RESPONSE DESCRIBING THE PERSON'S CURRENT LIVING ARRANGEMENTS:

☐ IN HOME ☐ WITH RELATIVE OR FRIEND ☐ NURSING FACILITY OR OTHER RESIDENTIAL FACILITY

☐ HOSPITAL ☐ OTHER (SPECIFY): _____

13. IS THE PERSON:

☐ A POTENTIAL ADMISSION OR TRANSFER TO A CERTIFIED BED? (PREADMISSION SCREENING)

☐ A CURRENT RESIDENT IN A CERTIFIED BED? (ANNUAL REVIEW)
IF THE PERSON IS CURRENTLY RESIDING IN A CERTIFIED BED, INDICATE THE MONTH AND YEAR THE PERSON ENTERED THE CERTIFIED NURSING BED _____

B. EXEMPTION CATEGORIES

C..CK ALL OF THE FOLLOWING WHICH DESCRIBE THE PERSON:

☐ ..4. HAS A PRIMARY DIAGNOSIS OF DEMENTIA (INCLUDING ALZHEIMER'S DISEASE OR RELATED DISORDER) MADE BY A PHYSICIAN BASED ON A NEUROLOGICAL EXAMINATION.

☐ 15. REFERRED TO THE NURSING FACILITY AFTER RELEASE FROM AN ACUTE CARE HOSPITAL FOR A CONVALESCENT STAY, I.E., A PERIOD NOT TO EXCEED 120 DAYS AS A PART OF A MEDICALLY PRESCRIBED PERIOD OF RECOVERY.

☐ 16. CERTIFIED BY A PHYSICIAN TO BE TERMINALLY ILL AND REQUIRING CONTINUOUS NURSING CARE AND/OR MEDICAL SUPERVISION AND TREATMENT DUE TO PHYSICAL CONDITION.

☐ 17. COMATOSE, VENTILATOR DEPENDENT, FUNCTIONS AT THE BRAIN STEM LEVEL, OR HAS A DIAGNOSIS OF CHRONIC OBSTRUCTIVE PULMONARY DISEASE, SEVERE PARKINSON'S DISEASE, HUNTINGTON'S DISEASE, AMYOTROPHIC LATERAL SCLEROSIS, OR CONGESTIVE HEART FAILURE.

IF ONE OR MORE OF THE ABOVE CATEGORIES WAS CHECKED, THE INDIVIDUAL MAY BE ADMITTED OR CONTINUE TO RESIDE IN A CERTIFIED BED.

PLEASE COMPLETE THE REMAINING SECTIONS OF THIS FORM.

C. SCREENING CRITERIA FOR MENTAL ILLNESS

18. HAS THE PERSON RECEIVED TREATMENT FOR A MENTAL ILLNESS WITHIN THE LAST TWO YEARS? ☐ YES ☐ NO

IF YES, INDICATE WHEN (I.E., MONTH/YEAR) AND WHERE MENTAL HEALTH TREATMENT WAS RECEIVED: _____

19. DOES THE PERSON HAVE A DIAGNOSIS OF ANY OF THE FOLLOWING AS DEFINED IN DSM-III R, SCHIZOPHRENIA, PARANOIA, MAJOR AFFECTIVE DISORDER, SCHIZOAFFECTIVE DISORDER OR ATYPICAL PSYCHOSIS? ☐ YES ☐ NO

2 ..ES, WAS THE DIAGNOSIS MADE BEFORE THE AGE OF 22? ☐ YES ☐ NO

21. DOES THE PERSON HAVE REGULARLY PRESCRIBED A MAJOR TRANQUILIZER OR OTHER PSYCHOTROPIC MEDICATIONS? ☐ YES ☐ NO

IF YES, LIST: (Please include dosage, frequency and indicate for what conditions) _____

MS 96-11

PERSON'S NAME	DATE OF BIRTH	SOCIAL SECURITY NUMBER	DCN NUMBER

22. DOES THIS INDIVIDUAL EXHIBIT BEHAVIORS WHICH WOULD LEAD YOU TO SUSPECT THAT THIS PERSON MAY 'AVE A MENTAL ILLNESS? ☐ YES ☐ NO

3. LIST ALL SPECIFIC BEHAVIORS WHICH SUGGEST MENTAL ILLNESS: _____

D. SCREENING CRITERIA FOR MENTAL RETARDATION/RELATED CONDITION

23. DOES THE PERSON HAVE A DIAGNOSIS OF MENTAL RETARDATION? ☐ YES ☐ NO

24. DOES THE PERSON HAVE A HISTORY OF A DEVELOPMENTAL DISABILITY THAT OCCURRED PRIOR TO 22 YEARS OF AGE? ☐ YES ☐ NO

25. DOES THE PERSON HAVE ANY CONDITION OR BEHAVIOR WHICH MIGHT LEAD YOU TO SUSPECT THAT THIS PERSON HAS A DEVELOPMENTAL DISABILITY OR MENTAL RETARDATION? ☐ YES ☐ NO

IF YES, DESCRIBE: _____

26. IS THE INDIVIDUAL BEING REFERRED BY AN AGENCY THAT SERVES PERSONS WITH MENTAL RETARDATION OR OTHER DEVELOPMENTAL DISABILITIES? ☐ YES ☐ NO

IF YES, INDICATE THE NAME OF THE AGENCY: _____

27. WAS THE INDIVIDUAL FOUND ELIGIBLE FOR THAT AGENCY'S SERVICES? ☐ YES ☐ NO

E. GENERAL SCREENING INFORMATION

28. LIST ALL CURRENT MEDICAL AND PSYCHIATRIC RELATED DIAGNOSES FOR THE INDIVIDUAL: _____

29. LIST ALL MEDICATIONS CURRENTLY PRESCRIBED FOR THE INDIVIDUAL: (Please include dosage and frequency) _____

30. WHAT IS THE SPECIFIC REASON FOR ADMISSION TO THE NURSING FACILITY? _____

F.

PHYSICIAN'S SIGNATURE	DATE	TELEPHONE NUMBER

FAILURE TO COMPLETE AND SUBMIT THE REQUIRED INFORMATION OR FALSIFYING INFORMATION ON THIS FORM MAY JEOPARDIZE AN INDIVIDUAL'S ABILITY TO ENTER OR CONTINUE RESIDENCE IN A MEDICAID CERTIFIED BED.

IF ALL QUESTIONS IN SECTIONS C AND D WERE ANSWERED "NO" AND THERE IS NO PSYCHIATRIC RELATED DIAGNOSIS, THE INDIVIDUAL MAY BE ADMITTED/CONTINUE RESIDENCE WITH NO FURTHER EVALUATION. THIS FORM IS TO BE RETAINED IN THE INDIVIDUAL'S MEDICAL RECORDS.

IF ANY QUESTIONS IN SECTIONS C OR D WERE ANSWERED "YES" OR THERE IS A PSYCHIATRIC RELATED DIAGNOSIS, COMPLETE THE DA-124A AND DA-124B AND SUBMIT ALL THREE COMPLETED FORMS TOGETHER TO THE DIVISION OF AGING, COMRU, 1440 AARON CT., JEFFERSON CITY, MO 65102. THE INDIVIDUAL MAY NOT BE ADMITTED TO A NURSING FACILITY UNTIL THE REQUIRED EVALUATION AND ELIGIBILITY DETERMINATIONS HAVE BEEN COMPLETED, UNLESS AN EXEMPTION WAS INDICATED IN SECTION B.

G. PERMISSION TO CONDUCT SCREENING/REVIEW

I, _____, GIVE CONSENT FOR THE MISSOURI DEPARTMENT OF SOCIAL SERVICES, THE MISSOURI DEPARTMENT OF MENTAL HEALTH AND THEIR LEGALLY AUTHORIZED REPRESENTATIVES TO OBTAIN INFORMATION FROM PHYSICIANS, HOSPITALS, PSYCHOLOGISTS, AND OTHER SERVICE PROVIDERS WHO HAVE INFORMATION RELEVANT TO THE DETERMINATION OF ELIGIBILITY FOR CARE IN A NURSING FACILITY. I ALSO UNDERSTAND THAT FURTHER EVALUATION MAY BE REQUIRED AND I AUTHORIZE THE DEPARTMENT OF MENTAL HEALTH TO RELEASE NECESSARY INFORMATION TO THE EVALUATION AGENCY.

SIGNATURE OF PERSON OR LEGAL GUARDIAN	DATE

Resident _____ Numeric Identifier _____

MINIMUM DATA SET (MDS) — *VERSION 2.0*
FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING
FULL ASSESSMENT FORM
(Status in last 7 days, unless other time frame indicated)

EXHIBIT 4
Page 1
MS 96-11

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

1. RESIDENT NAME — a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

2. ROOM NUMBER

3. ASSESSMENT REFERENCE DATE
a. *Last day of MDS observation period* — Month / Day / Year
b. Original (0) or corrected copy of form (enter number of correction)

4a. DATE OF REENTRY
Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days) — Month / Day / Year

5. MARITAL STATUS
1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

6. MEDICAL RECORD NO.

7. CURRENT PAYMENT SOURCES FOR N.H. STAY
(*Billing Office to indicate; check all that apply in last 30 days*)

Medicaid per diem	a.	VA per diem	f.
Medicare per diem	b.	Self or family pays for full per diem	g.
Medicare ancillary part A	c.	Medicaid resident liability or Medicare co-payment	h.
Medicare ancillary part B	d.	Private insurance per diem (including co-payment)	i.
CHAMPUS per diem	e.	Other per diem	j.

8. REASONS FOR ASSESSMENT
Note—If this is a discharge or reentry assessment, only a limited subset of MDS items need be completed
a. Primary reason for assessment
1. Admission assessment (required by day 14)
2. Annual assessment
3. Significant change in status assessment
4. Significant correction of prior assessment
5. Quarterly review assessment
6. Discharged—return not anticipated
7. Discharged—return anticipated
8. Discharged prior to completing initial assessment
9. Reentry
0. *NONE OF ABOVE*

b. *Special codes for use with supplemental assessment types in Case Mix demonstration states or other states where required*
1. *5 day assessment*
2. *30 day assessment*
3. *60 day assessment*
4. *Quarterly assessment using full MDS form*
5. *Readmission/return assessment*
6. *Other state required assessment*

9. RESPONSIBILITY/ LEGAL GUARDIAN
(*Check all that apply*)

Legal guardian	a.	Durable power attorney/financial	d.
Other legal oversight	b.	Family member responsible	e.
Durable power of attorney/health care	c.	Patient responsible for self	f.
		NONE OF ABOVE	g.

10. ADVANCED DIRECTIVES
(*For those items with supporting documentation in the medical record, check all that apply*)

Living will	a.	Feeding restrictions	f.
Do not resuscitate	b.	Medication restrictions	g.
Do not hospitalize	c.	Other treatment restrictions	h.
Organ donation	d.		
Autopsy request	e.	*NONE OF ABOVE*	i.

SECTION B. COGNITIVE PATTERNS

1. COMATOSE (*Persistent vegetative state/no discernible consciousness*)
0. No 1. Yes (If yes, skip to Section G)

2. MEMORY (*Recall of what was learned or known*)
a. Short-term memory OK—seems/appears to recall after 5 minutes
0. Memory OK 1. Memory problem
b. Long-term memory OK—seems/appears to recall long past
0. Memory OK 1. Memory problem

3. MEMORY/ RECALL ABILITY (*Check all that resident was normally able to recall during last 7 days*)

Current season	a.	That he/she is in a nursing home	d.
Location of own room	b.		
Staff names/faces	c.	*NONE OF ABOVE* are recalled	e.

4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING (*Made decisions regarding tasks of daily life*)
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS (*Code for behavior in the last 7 days.*) [*Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time*].
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, *etc; frequent position changes;* repetitive physical movements or calling out)
e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

6. CHANGE IN COGNITIVE STATUS Resident's cognitive status, skills, or abilities have changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION C. COMMUNICATION/HEARING PATTERNS

1. HEARING (*With hearing appliance, if used*)
0. *HEARS ADEQUATELY*—normal talk, TV, phone
1. *MINIMAL DIFFICULTY* when not in quiet setting
2. *HEARS IN SPECIAL SITUATIONS ONLY*—speaker has to adjust tonal quality and speak distinctly
3. *HIGHLY IMPAIRED*/absence of useful hearing

2. COMMUNICATION DEVICES/ TECHNIQUES (*Check all that apply during last 7 days*)

Hearing aid, present and used	a.
Hearing aid, present and not used regularly	b.
Other receptive comm. techniques used (e.g., lip reading)	c.
NONE OF ABOVE	d.

3. MODES OF EXPRESSION (*Check all used by resident to make needs known*)

Speech	a.	Signs/gestures/sounds	d.
Writing messages to express or clarify needs	b.	Communication board	e.
American sign language or Braille	c.	Other	f.
		NONE OF ABOVE	g.

4. MAKING SELF UNDERSTOOD (*Expressing information content—however able*)
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

5. SPEECH CLARITY (*Code for speech in the last 7 days*)
0. *CLEAR SPEECH*—distinct, intelligible words
1. *UNCLEAR SPEECH*—slurred, mumbled words
2. *NO SPEECH*—absence of spoken words

6. ABILITY TO UNDERSTAND OTHERS (*Understanding verbal information content—however able*)
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

7. CHANGE IN COMMUNICATION/ HEARING Resident's ability to express, understand, or hear information has changed as compared to status of 90 days ago (or since last assessment if less than 90 days)
0. No change 1. Improved 2. Deteriorated

SECTION D. VISION PATTERNS

1.	VISION	(*Ability to see in adequate light and with glasses if used*) 0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books 1. *IMPAIRED*—sees large print, but not regular print in newspapers/books 2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects 3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects 4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects	
2.	VISUAL LIMITATIONS/ DIFFICULTIES	Side vision problems—decreased peripheral vision (e.g., leaves food on one side of tray, difficulty traveling, bumps into people and objects, misjudges placement of chair when seating self)	a.
		Experiences any of following: sees halos or rings around lights; sees flashes of light; sees "curtains" over eyes	b.
		NONE OF ABOVE	c.
3.	VISUAL APPLIANCES	Glasses; contact lenses; magnifying glass 0. No 1. Yes	

SECTION E. MOOD AND BEHAVIOR PATTERNS

1.	INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD	(*Code for indicators observed in last 30 days, irrespective of the assumed cause*) 0. Indicator not exhibited in last 30 days 1. Indicator of this type exhibited up to five days a week 2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)	
		VERBAL EXPRESSIONS OF DISTRESS	
		a. Resident made negative statements—e.g., "*Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die*"	
		b. Repetitive questions—e.g., "*Where do I go; What do I do?*"	
		c. Repetitive verbalizations—e.g., calling out for help, ("*God help me*")	
		d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received	
		e. Self deprecation—e.g., "*I am nothing; I am of no use to anyone*"	
		f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others	
		g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack	
		h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions	
		i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing; relationship issues	
		SLEEP-CYCLE ISSUES	
		j. Unpleasant mood in morning	
		k. Insomnia/change in usual sleep pattern	
		SAD, APATHETIC, ANXIOUS APPEARANCE	
		l. Sad, pained, worried facial expressions—e.g., furrowed brows	
		m. Crying, tearfulness	
		n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking	
		LOSS OF INTEREST	
		o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends	
		p. Reduced social interaction	
2.	MOOD PERSISTENCE	One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days 0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered	
3.	CHANGE IN MOOD	Resident's mood status has changed as compared to status of 90 days ago (or since last assessment if less then 90 days) 0. No change 1. Improved 2. Deteriorated	
4.	BEHAVIORAL SYMPTOMS	(A) *Behavioral symptom frequency in last 7 days* 0. Behavior not exhibited in last 7 days 1. Behavior of this type occurred 1 to 3 days in last 7 days 2. Behavior of this type occurred 4 to 6 days, but less than daily 3. Behavior of this type occurred daily (B) *Behavioral symptom alterability in last 7 days* 0. Behavior not present OR behavior was easily altered 1. Behavior was not easily altered	(A) (B)
		a. WANDERING (moved with no rational purpose, seemingly oblivious to needs or safety)	
		b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)	
		c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)	
		d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)	
		e. RESISTS CARE (resisted taking medications/ injections, ADL assistance, or eating)	

5.	CHANGE IN BEHAVIORAL SYMPTOMS	Resident's behavior status has changed as compared to status of 90 days ago (or since last assessment if less than 90 days) 0. No change 1. Improved 2. Deteriorated	

SECTION F. PSYCHOSOCIAL WELL-BEING

1.	SENSE OF INITIATIVE/ INVOLVEMENT	At ease interacting with others	a.
		At ease doing planned or structured activities	b.
		At ease doing self-initiated activities	c.
		Establishes own goals	d.
		Pursues involvement in life of facility (e.g., makes/keeps friends; involved in group activities; responds positively to new activities; assists at religious services)	e.
		Accepts invitations into most group activities	f.
		NONE OF ABOVE	g.
2.	UNSETTLED RELATIONSHIPS	Covert/open conflict with or repeated criticism of staff	a.
		Unhappy with roommate	b.
		Unhappy with residents other than roommate	c.
		Openly expresses conflict/anger with family/friends	d.
		Absence of personal contact with family/friends	e.
		Recent loss of close family member/friend	f.
		Does not adjust easily to change in routines	g.
		NONE OF ABOVE	h.
3.	PAST ROLES	Strong identification with past roles and life status	a.
		Expresses sadness/anger/empty feeling over lost roles/status	b.
		Resident perceives that daily routine (customary routine, activities) is very different from prior pattern in the community	c.
		NONE OF ABOVE	d.

SECTION G. PHYSICAL FUNCTIONING AND STRUCTURAL PROBLEMS

1. (A) ADL SELF-PERFORMANCE—(*Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup*)
   - 0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
   - 1. SUPERVISION—Oversight, encouragement or cueing provided 3 or more times during last7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
   - 2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
   - 3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
     - —Weight-bearing support
     - —Full staff performance during part (but not all) of last 7 days
   - 4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
   - 8. *ACTIVITY DID NOT OCCUR* during entire 7 days

   (B) ADL SUPPORT PROVIDED—(*Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification*)
   - 0. No setup or physical help from staff
   - 1. Setup help only
   - 2. One person physical assist
   - 3. Two+ persons physical assist
   - 8. ADL activity itself did not occur during entire 7 days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). If facility has only one floor, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of street clothing, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		